

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-015932

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 284

Primary Registration District No. 3037

Registrar's No. 88

VS 300
Rev. 4/59

10585

20585

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1290-3

132-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 7 1962

1. PLACE OF DEATH
a. COUNTY Linn

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Brookfield

Length of stay in lb
88 years

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION 721 West Helm

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Linn

c. CITY OR TOWN Brookfield

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
721 West Helm

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First Middle Last
ALBERT SMITH REAMS

4. DATE OF DEATH
Month Day Year
April 30, 1962

5. SEX male

6. COLOR OR RACE white

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH
6/30/1873

9. AGE (last birthday)
88

IF UNDER 1 YEAR
Months Days Hours Min.

IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Owner of Transfer Storage

10b. KIND OF BUSINESS OR INDUSTRY
Transfer business

11. BIRTHPLACE (City and state or country)
Brookfield, Mo.

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME
Otho Reams

13b. MOTHER'S MAIDEN NAME
Marietta Smith

14. NAME OF HUSBAND OR WIFE
Stella Reams (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.
[REDACTED]

17. INFORMANT
Alys Culler, Marceline, Missouri

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Senility

INTERVAL BETWEEN ONSET AND DEATH
unknown

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____ to _____ and last saw her him alive on _____.
Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL CREMATION REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Funeral Home, Brookfield, Mo. May 2 1962 Anna Watson

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4822

P. O. Address Chulucillo Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.